New York State
Medicaid Redesign Team (MRT) Waiver

1115 Research and Demonstration Waiver

#11-W-00114/2

Managed Long Term Care Plan Eligibility and Voluntary Mainstream Enrollment for Certain Dual Eligibles

Amendment Request

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NEW YORK STATE | Department of Health

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Introduction

Pursuant to the terms of the New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team Plan (11-W-00114/2), the New York State Department of Health (the State or the Department) is pleased to submit this waiver amendment proposal to the Centers for Medicare and Medicaid Services (CMS) for its approval. This amendment would modify enrollment eligibility criteria for Managed Long-Term Care (MLTC) plans and dual eligible Medicaid beneficiaries under the demonstration.

Statement of Purpose

This amendment would modify the eligibility criteria for MLTC plans to require, in addition to having a need of Community-Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days, individuals must be found to have a need for at least limited assistance (ranging from limited assistance to total dependence) with more than two activities of daily living (ADL) determined using the state's Community Health Assessment (CHA) tool. If an individual has a Dementia/Alzheimer's diagnosis, the individual must be found to need at least supervision with more than one ADL, as determined by the CHA.

This amendment will also allow individuals dually eligible for Medicare and Medicaid services who do not meet the CLBTCS requirements needed to enroll in an MLTC plan (i.e., "well duals") and who voluntarily enroll in a Medicare D-SNP with a qualified Mainstream Medicaid Managed Care (MMMC) plan to remain voluntarily, or be enrolled voluntarily, in the qualified and affiliated MMMC plan through an exemption for this specific population.

Both components of this request will allow the State to continue its existing delivery system transformation efforts, including providing integrated care for dual eligible beneficiaries, increasing efficiencies across delivery systems, and to continue down the road to value-based care.

Effect on Recipients

The amendment does not affect the overall Medicaid eligibility of any individuals. To avoid any impact on recipients currently enrolled in MLTC plans, individuals enrolled in MLTC plans continuously as of December 31, 2020 will remain eligible and be reassessed using the former criteria applicable prior to January 1, 2021. If the individual's eligibility changes and/or he/she wants to change from MLTC plans, the former criteria will be used to determine eligibility for either plan.

It is anticipated that 6,300 well dual eligible beneficiaries will remain voluntarily enrolled in the same qualified and affiliated MMMC plan. No changes to budget neutrality per member, per month (PMPM) costs are projected because the MLTC plans will continue to provide the same services to individuals in need of CBLTCS. The MMMC benefit packages are also not changing.

Goals and Objectives

Currently, MMMC enrollees that become a dual eligible beneficiary are disenrolled from their plan. Duals who do not need CBLTCS are disenrolled to fee-for-service, while dual eligible beneficiaries that need CBLTCS are enrolled in a partial capitation MLTC plan. Under this amendment, qualifying dual eligibles who voluntarily enroll in a Medicare D-SNP will be voluntarily enrolled in the same qualified MMMC plan. CBLTCS include nursing services in the home; therapies in the home; home health aide services; personal care services in the home; adult day health care; private duty nursing; and Consumer Directed Personal Assistance Services, which are all State Plan services available under the regular State Plan in the fee-for-service delivery system.

This amendment increases the efficiency of our delivery systems by providing dual eligible individuals pathways to integrated products and ensuring members with ADL needs are enrolled

in MLTC. These efficiencies will ensure ongoing sustainability of Medicaid as a critical safety net program.

Amendment Background/History/Program

Presently, Medicaid members who are duals primarily receive their Medicaid benefits in fee-for-service or are enrolled in MLTC plans. Those dual eligible members may be enrolled in a Medicare Advantage Plan (Medicare managed care) or Medicare fee-for-service. For these duals, their Medicare and Medicaid benefits are not coordinated and are managed by different entities, creating challenges to coordinate care and potential confusion for individuals who must navigate two benefit packages across different entities.

This amendment provides that only eligible members, including dual eligibles, requiring the enhanced Medicaid care coordination and CBLTCS available in MLTC would be enrolled in an MLTC plan. Other dual eligibles would be in regular fee-for-service delivery systems where Medicare benefits would be coordinated under the Medicare program with Medicaid payment of cost sharing. Full benefit well dual eligibles who voluntarily enroll in a Medicare D-SNP with a qualified and affiliated Mainstream plan will be voluntarily enrolled in the same plan.

Amendment Program Overview

Once the amendment is approved, eligibility documentation for the MLTC and MMMC plans will be updated to reflect this clarification.

Transition Plan for Amendment Population

Full benefit well duals who voluntarily enroll in a Medicare D-SNP with a qualified MMMC plan will be voluntarily enrolled in the same qualified MMMC plan. If the well dual eligible individual opts into a Medicare Advantage product or Medicare fee-for-service, the well dual eligible will be disenrolled into fee-for-service.

Eligible Population

This amendment makes the following underlined changes outlined below to page 21 of the STCs regarding MMMC eligibility:

Table 2: Individuals Excluded from MMMC (including HARP and HIV SNP)
<u>Medicare recipients who are not enrolled in a Medicare D-SNP with a qualified MMMC plan</u>

Table 3: Individuals who may be exempted from MMMC (including HARP and HIV SNP)
<u>Medicare recipients who are enrolled in a Medicare D-SNP with a qualified MMMC plan</u>

This amendment makes the following underlined changes outlined below to pages 21-22 of the STCs regarding MLTC eligibility:

> **Managed Long Term Care (MLTC)**. This component provides a limited set of Medicaid state plan benefits including long term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community based long term care services <u>and have performance needs in more than two activities of daily living (ADL) of limited assistance or greater (ranging from limited assistance to total dependence) or if Dementia/Alzheimer's diagnosis is present, performance needs with more than one ADL needing at least supervision</u> as indicated on the uniform assessment tool. See Attachment B for a listing of MLTC services. Services not provided through the MLTC program are provided on a fee-for-service

basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in under the MLTC column in Table 1 (except those otherwise excluded or exempted as outlined in 3(a)(ii) of this section).

i. **Eligibility for MLTC.** Table 1 above lists the groups of individuals who may be enrolled in the Managed Long Term Care component of the demonstration as well as the relevant expenditure reporting category (demonstration population) for each. To be eligible, all individuals in this program must need more than 120 days of community based long term care services and have performance needs in more than two activities of daily living (ADL) of limited assistance or greater (ranging from limited assistance to total dependence) or if Dementia/Alzheimer's diagnosis is present, performance needs with more than one ADL needing at least supervision as indicated on the uniform assessment tool. PACE must also have a nursing home level of care.

This amendment makes the following changes underlined changes outlined below to Attachment G of the STCs regarding MLTC eligibility:

ATTACHMENT G
Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Effective January 1, 2021:

Mandatory Population: Dual eligible, age 21 and over, receiving CBLTCS for over 120 days, and have performance needs in more than two ADLs of limited assistance or greater (ranging from limited assistance to total dependence) or if a Dementia/Alzheimer's diagnosis is present, performance needs with more than one ADL needing at least supervision as indicated on the uniform assessment tool, excluding the following:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Assisted Living Program participants; and
- Dual eligibles who do not require community based long term care services.

Voluntary Population: Dual eligible, age 18 through 20, in need of CBLTCS for over 120 days and assessed to have performance needs in more than two ADLs of limited assistance or greater (ranging from limited assistance to total dependence) or if a Dementia/Alzheimer's diagnosis is present, performance needs with more than one ADL needing at least supervision, as indicated on the uniform assessment tool. Non-dual eligible age 18 and older assessed to be in need of community based long term care services for over 120 days and assessed to have performance needs in more than two ADLs of limited assistance or greater (ranging from limited assistance to total dependence) or if a Dementia/Alzheimer's diagnosis is present, performance needs with more than one ADL needing at least supervision as indicated on the uniform assessment tool.

Benefits

The benefits are the same as currently approved under the program. The State will follow the notification procedures outlined in STCs on page 34 for Adding Services to the MMMC and/or MLTC Plan Benefit Package.

New York believes this proposal will have limited impact on the evaluation design. The MLTC eligibility criteria changes will be implemented only for new enrollees once this waiver amendment is approved in 2021 and will not apply to current MLTC enrollees who have determined eligible to receive CBLTCS prior to the effective date of the waiver amendment. The goal of the eligibility criteria changes is to capture those with more complex and intensive needs to improve quality, care coordination and health outcomes. Quality measures incorporating this new population will occur for measurement year 2022.

As this component of the waiver amendment will apply to a new population, initial and/or new assessments are excluded from quality performance measurement. New York will include questions in its next Evaluation Plan that will assess the impact of the new eligibility criteria. The new eligibility criteria will be assessed by utilizing monthly enrollment data and evaluating new member assessment information.

Accordingly, New York is considering the addition of three new descriptive questions:

1) Did the number of enrollees in the MLTC program change in the 12 months following the new eligibility criteria compared to the previous 12 months?

2) Did the new enrollees into MLTC in the 12 months following the new eligibility criteria have a higher level of care need?

3) How were new enrollees Activities of Daily Living needs different from the new enrollees in the previous 12 months?

Moreover, due to the technical nature of the change for MMC eligibility, New York does not anticipate any evaluation design impact on the MMC full benefit dual eligibles that would remain in the MMC population. As noted, the benefit package will not change and the population to remain in Mainstream is limited to those that are not eligible for CBLTCS.

The State is not seeking any new waiver or expenditure authority under the demonstration amendment.

MLTC plans will continue to provide the same services to individuals in need of CBLTCS under the amended enrollment eligibility criteria. The MMMC plan benefit package will similarly not change. Therefore, no changes to budget neutrality per member, per month (PMPM) costs are projected and the state anticipates that the overall savings for the MLTC plan enrollment eligibility amendment will be $4.9M and will impact 4,700 members.

Please refer to the attached Budget Neutrality spreadsheet in Attachment III for the necessary budget neutrality documentation and information.

The Department sought public input regarding the proposed modification to the MLTC eligibility criteria requirements for those in need of CBLTSS as well as the proposal to allow certain dual eligibles in a qualified Mainstream plan to remain in that plan once they become Medicare eligible.

Letters were sent to Tribal leaders and colleagues in Indian Health Centers on July 28, 2020. No comments were received in response. In addition, several virtual meetings were held for advocacy groups, health plan associations, consumers, and other stakeholders on July 13, 2020, July 14, 2020, July 20, 2020, July 21, 2020, July 27, 2020, July 28, 2020 and July 31, 2020. Public notice was posted in the NYS Register on August 12, 2020.

There were twenty-four (24) separate comments received from two consumer advocacy groups and one health plan association. There were six comments focused on the change in minimum ADLs required to meet eligibility criteria and limitations on the diagnoses eligible for CBLTSS. The Department appreciates the comments and recommendations offered by stakeholders to this proposal. No specific changes were made to the waiver amendment in response because the comments speak to the means through which the Department will implement and apply the new ADL requirements through its assessment process, which the Department will update in conjunction with the effective date of this amendment. Additionally, in response to these comments, the Department notes that the change in criteria does not impact those currently enrolled in an MLTC, and any reassessment of such individuals will continue to be conducted using the existing MLTC eligibility criteria. Finally, these comments also asked whether this new assessment criteria would deny access to services solely based on diagnosis. In response, the Department clarifies that this amendment would not result in the denial of access to the types of community based long-term care services furnished through MLTC plans, as affected individuals will remain entitled for all fee-for-service and MMMC services for which they qualify, which are either already in place to address their needs or may be subject to future care linkages coordinated by the individuals' local departments of social services or MMMC plans (or their subcontracted care management agencies).

There was one comment requesting clarification of the treatment of the long-term nursing home stay population as it relates to default enrollment eligibility for MLTC and Medicare D-SNPs. The amendment does not modify enrollment exclusions from MLTC. Under current enrollment rules, the long-term nursing home stay population is only excluded from enrollment in partially capitated MLTCs. Therefore, eligible beneficiaries in long-term nursing home stays may be included in approved default enrollment arrangements to an aligned Medicare D-SNP and Medicaid Advantage Plus MLTC plan as they become dually eligible for Medicaid and Medicare.

The remaining comments received were related to operational issues of the default enrollment process for the well duals population who will remain in Mainstream once they become Medicare eligible. Stakeholders raised concerns with ensuring enrollees are aware of opt out rules, timelines and voluntary nature of default enrollment. Other comments raised included how the redetermination process would change as enrollees' transition from MAGI to non-MAGI reviews upon becoming Medicare eligible that could result in loss of Medicaid eligibility.

Additionally, stakeholders commented on care coordination and how integration would be achieved for dual eligibles based on benefits and providers that may differ between Medicare and Medicaid.

The Department appreciates the detailed comments made by the stakeholders to this proposal. Our goals to provide more integrated care to dual eligibles is carried out in partnership with the Medicare Medicaid Coordination Office (MMCO). The Department continues to work with that office in the implementation of default enrollment to coordinate benefits and services for the dual eligible population. As such, the Department has identified and addressed many of the issues raised in the comments, including:

- Development of processes to ensure opt out notice requirements and resources available to assist enrollees with questions or who choose to opt out of default enrollment.
- Development of educational materials in collaboration with health plan associations and consumer groups, which describe options available to fit the needs of dual eligibles and discuss best practices. The Department is considering focus group reviews of materials and member notices to obtain additional feedback from dual eligibles and/or caregivers.
- The Department is working closely with interested MMMC plans to review readiness, provider network overlap and operational processes to ensure qualified participating MMMC plans. This preparatory work will allow for a transition that is seamless to the member who can now receive all of their care through one plan.
- The Department has utilized the "maintenance of effort" period under Section 6008 of the Families First Coronavirus Response Act to refine systems readiness and plan for advance notice of redeterminations to be aligned with Medicare eligibility.
- The Department will make approved default enrollment plans publicly available on its website.

Statement of Purpose

Effective with the date of the approval of the 1115, MLTC members must be found to be in need of Community-Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days and i) to need limited assistance or greater (ranging from limited assistance to total dependence) with more than two activities of daily living (ADLs); or ii) if a Dementia/Alzheimer's diagnosis is present, to need at least supervision with more than one ADL, as measured by the Community Health Assessment. To avoid any impact on recipients currently enrolled in MLTC, New York will not apply the new MLTC criteria to individuals who have been continuously enrolled prior to the effective date of the new criteria. If the individual's eligibility changes and/or he/she wants to change from MLTC plans, the former criteria will be used to determine eligibility for either plan.

Individuals found to not meet these criteria will be considered "well duals." Full benefit well dual eligibles who voluntarily enroll in a Medicare D-SNP with a qualified Mainstream Medicaid Managed Care (MMMC) plan will remain voluntarily, or be enrolled voluntarily, in the qualified MMMC plan through an exemption for this specific well dual population. Well dual eligible individuals that choose a Medicare Advantage product or Medicare fee-for-service will be disenrolled into fee-for-service.

Background/History

This amendment implements provisions contained in the New York State Enacted State Fiscal Year 2020-21 Budget and the work and recommendations of the Medicaid Redesign Team II (MRT II), increases efficiencies across delivery systems, and facilitates the optional enrollment in integrated products for New York's dual eligibles. These efficiencies will ensure ongoing sustainability of Medicaid as a critical safety net program.

Transition Plan

Enrollees in MMMC who become dual eligible and enroll in a Medicare D-SNP with a qualified MMMC plan will remain in their plan. If the well dual eligible individuals choose to enroll in a Medicare Advantage product or Medicare fee-for-service, the well dual eligible will be disenrolled into fee-for-service.

To avoid any impact on recipients currently enrolled in an MLTC plan, New York will not apply the new MLTC eligibility criteria to individuals who have been continuously enrolled prior to the effective date of the new criteria.

Benefits

No changes are proposed at this time through this amendment. The benefits are the same as currently approved under the program. The State will follow the notification procedures outlined in STCs on page 34 for Adding Services to the MMMC and/or MLTC Plan Benefit Package.

Transition Objectives

The State will ensure that all beneficiaries understand how to access their Medicare and Medicaid services under the fee-for-service and managed care delivery systems.

Effect on Recipients

The amendment does not affect the Medicaid eligibility of any individuals. In order to reduce the effect on recipients currently enrolled in MLTC, individuals enrolled in MLTC plans continuously as of December 31, 2020 will remain eligible and be reassessed using the former criteria applicable prior to January 1, 2021. If the individual's eligibility changes and/or he/she wants to change from MLTC plans, the former criteria will be used to determine eligibility for either plan.

It is anticipated that 6,300 well dual eligibles will remain voluntarily enrolled in the same qualified Mainstream plan. No changes to budget neutrality per member, per month (PMPM) costs are projected because the MLTC plans will continue to provide the same services to individuals in need of CBLTCS. The MMMC benefit packages are also not changing.

Public Notice

The State conducted a public comment period to solicit input on the waiver transition. See the "Public Notice Process" section for additional information.

Attachment II - Historical Description Federal and State Waiver Authority

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) for its Partnership Plan Medicaid Section 1115 Demonstration. In implementing the Partnership Plan Demonstration, it was the State's goal to:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered;
- Expand access to family planning services; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The Partnership Plan Demonstration was originally authorized for a five-year period and has been extended several times. CMS had approved an extension of the 1115 waiver on September 29, 2006 for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short-term extensions while negotiations continued renewing the waiver into 2016.

There have been several amendments to the Partnership Plan Demonstration since its initial approval in 1997. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team (MRT). CMS recently approved the DSRIP and Behavioral Health amendments to the Partnership Plan Demonstration on April 14, 2014 and July 29, 2015, respectively.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. Populations in the F-SHRP were transitioned into the 1115 Partnership Plan Waiver. A final draft evaluation report was submitted to CMS on February 11, 2015 and was approved by CMS on May 24, 2016.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as complete and posted the application for a 30-day public comment period. A temporary extension was granted on December 31, 2014 which extended the waiver through March 31, 2015. Subsequent temporary extensions were granted through December 7, 2016. New York's 1115 Demonstration was renewed by CMS on December 7, 2016 through March 31, 2021. At the time of renewal, the Partnership Plan was renamed New York Medicaid Redesign Team (MRT) Waiver.

New York is well positioned to lead the nation in Medicaid reform. Governor Cuomo´s Medicaid Redesign Team (MRT) has developed a multi-year action plan (A Plan to Transform the Empire State´s Medicaid Program) that when fully implemented will not only improve health outcomes

for more than five million New Yorkers but also bend the state´s Medicaid cost curve. Significant federal savings have already been realized through New York´s MRT process and substantial savings will also accrue as part of the 1115 waiver.

Please refer to the following excel file: NY MRT Budget Neutrality – MLTCP MAP Eligibility UPDATED.xlsx